ASiT The Association of Surgeons in Training

Introduction: Touch Imprint Cytology (TIC) allows intra-operative assessment of axillary lymph nodes, determining progression to axillary lymph node dissection at the same operation and requires specialist cytopathologists. We present our experience in a District General Hospital.
Methods: A prospective study of consecutive series of patients undergoing level II or III axillary lymph node dissection, from October 2006 to September 2007, was undertaken. One surgeon and three cytopathologists were involved. TIC of a random level I lymph node was compared with imprint node histology. Cytopathologists were blinded to the use of coated and uncoated slides, used for each case.
Results: 38/42 consecutive cases were analysed (4 exclusions as uninterpretable).Mean axillary yield 13.7. 12 TIC nodes were positive, all imprint nodes positive in these cases. 26 TIC nodes negative, all imprint nodes negative in these cases. Sensitivity = 100%, specificity = 100%, false negative rate 0, P <0.0001 (Fischer's exact T-Test). Pathologists observed no difference in coated and uncoated slides.
Conclusion: Our data suggests TIC of intra-operative lymph nodes is a useful tool in a District General setting for determining whether or not to proceed to full ALND at that operation. A dedicated surgical team and cytopathology department is required. Coated or uncoated slides can be used.

THE INFLUENCE OF TOUCH-IMPRINT CYTOLOGY ON FURTHER MANAGEMENT FOR BREAST CANCER PATIENTS

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Aims: Touch imprint cytology (TIC) maximises the benefits of sentinel lymph node biopsy (SLNB) by allowing completion axillary lymph node dissection (ALND) during the same operation if the SLN is cancer-positive. The aim of this study was to establish and compare TIC sensitivity for macro- and micrometastases, and to examine management after a false-negative TIC.
Methods: Patients were selected for SLNB by axillary ultrasound and FNAC if indicated. All patients with invasive breast cancer undergoing SLNB with TIC between May 2006 and September 2009 were analysed. Results of TIC were compared with final histology.
Results: 367 cases were submitted for TIC. 84 cases (23%) were node-positive. TIC had a sensitivity and specificity of 51% and 100%. TIC sensitivity for macrometastases and micrometastases was 69% and 8% respectively. 43 cases were tumour-positive on TIC of which 40 had macrometastases; all underwent immediate completion ALND. 41 node-positive cases were not identified by TIC. 23 (56%) had micrometastatic disease. 33 (80%) underwent delayed completion ALND.
Conclusions: TIC has only moderate sensitivity after pre-operative selection with axillary ultrasound (+/- FNAC). A high proportion of patients with false-negative TIC results have micrometastases and this appears to affect their ongoing management.

AUDIT OF PERFORMANCE OF DAY CASE SURGICAL UNIT IN A DISTRICT GENERAL HOSPITAL

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Aims: To evaluate the performance of Day Case Unit (DCU) against the recommendation by the British Association of Day Surgery (BADS).
Methods: A retrospective audit of DCU for three surgical procedures over one year; Laparoscopic Cholecystectomy (LC), Primary Inguinal Hernia Repair (PIHR) and Primary Varicose Vein Surgery (PVVS). Procedure to be done as day case in recommendation by BADS; LC = 90%, PIHR = 90% and PVVS = 100%. The day case was defined as patient discharge within 23 hours and 59 minutes.
Results: 826 cases were listed in DCU, 6% (48/826) cancelled therefore 778 included in the analysis. Procedures performed: LC 28% (n = 222), PIHR 38% (n = 294) and PVVS 34% (n = 262). Procedure performed as day case; LC 79 % (176/222), PIHR 90% (265/294) and PVVS 97% (256/262). Commonest reason for cancellation was patient did not arrive (23%, n = 11), other reasons were theatre list over run 16% (n = 8), bed not available 13% (n = 6), cancelled by anaesthetist 13% (n = 6), unfit for surgery 10% (n = 5), emergency work 10% (n = 5) and miscellaneous 15% (n = 7).
Conclusions: The performance of DCU at this hospital is comparable to the recommendation by BADS. Further improvement is achievable by careful planning while listing the patients and by pre-operative assessment of all patients.

IMPLICATIONS OF POST OPERATIVE CHEST INFECTIONS AND UNEXPECTED RETURNS TO INTENSIVE CARE UNIT FOLLOWING OESOPHAGECTOMY FOR CANCER

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Introduction: Oesophageal cancer has poor outcomes. Work has demonstrated that post-operative complications particularly chest infections following oesophagectomy can reduce long-term survival, presumably through disrupted immunological surveillance. We investigated whether an unexpected return to ITU or documented chest infection were associated with poorer survival following oesophagectomy.
Methods: The setting is a collaborative cardiac-thoracic-upper GI unit. All patients who underwent oesophageal resection for cancer from 2002-2008 were included. Univariate and multivariate analyses were performed.
Results: 313 patients were identified with overall 5-year survival of 37%. In-hospital mortality was greater in patients with chest infection and unexpected returns to ITU ($p < 0.001$). On univariate analysis there was a trend for chest infection to be associated with poorer survival ($p = 0.054$). On multivariate analysis predictors of poorer survival were T stage, N stage ($p < 0.001$) and also the presence of chest infection ($p = 0.034$). However, following exclusion of in-patient deaths a difference in overall survival following a chest infection or unexpected return could not be demonstrated ($p = 0.791$ and $p = 0.465$).
Conclusions: The presence of pneumonia following oesophagectomy appears to reduce overall survival through short-term effects (i.e. in patient mortality). In contrast to published data we were unable to demonstrate any adverse survival effects following chest infection or return to ITU.

THE FEASIBILITY OF DEFERRED CHOLECYSTECTOMY IN ELDERLY PATIENTS WITH OBSTRUCTIVE GALLSTONE DISEASE (OGSD) FOLLOWING SUCCESSFUL ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP) – A COMPARATIVE OBSERVATIONAL ANALYSIS

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Aims: ERCP is usually performed in OGSD patients. Most patients are subsequently counselled for cholecystectomy. This may be associated with significant morbidity in elderly patients. This study aims to assess if cholecystectomy can be safely deferred in elderly patients following successful ERCP for OGSD.
Methods: All patients >75 year-old with OGSD, who underwent ERCP (June 2004-2008) in 2 centres, were included. Information regarding stenting, complications (failure, bleeding, cholangitis and stent migration), 30-day mortality and symptoms recurrence was retrospectively collected. The median follow-up period was 9 (6-36) months. Difference in ERCP outcome between the 2 centres was assessed by two-tailed t-test.
Results: Centre 1(n = 54) Centre 2(n = 51) Total (n = 105) Sphincterotomy only 33(61.1%) 29(56.9%) 62(59%) Stent insertion 21(38.9%) 22(43.1%) 43 (41%) Complications 3(5.6%) 7(13.7%) 10(9.5%) 30-day mortality 3(5.6%) 1 (2%) 4(3.8%) Symptoms recurrence 11(20.4%) 5(9.8%) 16(15.2%) Cholecystectomy 4(7.4%) 11(21.6%) 15(14.3%) Overall, 85.7% of patients did not require cholecystectomy during the follow-up period. There was no difference between centres regarding number of stents inserted and 30-day mortality (p>0.05). Centre 2 had a higher cholecystectomy and ERCP complication rate (p < 0.05%).
Conclusions: The preliminary data suggests that cholecystectomy is not required in the majority of elderly patients with OGSD following successful ERCP. Longer follow-up is needed to determine if ERCP offers definitive treatment.

ROLE OF ULTRASOUND GUIDED TRANSVERSUS ABDOMINIS PLANE (USTAP) BLOCK IN ANALGESIC SUPPLEMENTATION FOR LAPAROSCOPIC RADICAL PROSTATECTOMY. PRELIMINARY FINDINGS

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Introduction: Ultrasound Guided Transversus Abdominis Plane (USTAP) Block is a new regional anaesthetic technique that aims to block the abdominal neural afferents by instillation of local anaesthetic into the neurofascial plane that lies between the transversus abdominis and internal oblique musculature. We conducted a preliminary evaluation of the analgesic efficacy of this approach for Laparoscopic Radical Prostatectomy (LRP).
Methods: Forty men undergoing LRP were given different modes of analgesia. Group 1 had general anaesthetic (GA) alone, Group 2 had GA and epidural, Group 3 had GA and patient controlled analgesia and Group 4 had bilateral USTAP Block. Post-operatively all groups received acetaminophen and non-steroidal anti-inflammatories as required. Each patient was objectively assessed at 24 hours.
Results: The percentages of patients requiring morphine in the first 24 hours / the mean visual analogue pain scores at 24 hours were: Group 1 – 47/3.5; Group 2 – 100/3.0; Group 3 – 100/2.0; Group 4 – 47/1.2.
Conclusions: USTAP Block offers satisfactory analgesic effects for patients undergoing LRP and appears to be safe with no complications. The role of USTAP in LRP and other minimally invasive urological procedures should be explored further.

THE ROLE OF BONE SCAN AND PSA IN PATIENTS WITH NEWLY DIAGNOSED PROSTATE CANCER

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Objective: To determine if bone scanning is necessary in newly diagnosed cases of prostate cancer with PSA < 20ng/ml.
Material and methods: We analyzed the data of all our 246 patients with newly diagnosed prostate cancer from January 2007 to January 2009. We excluded 18 of these patients without histology or bone scan leaving 228 patients.
Results: 44 patients had a positive bone scan, of which 37 were confirmed with further radiological imaging. Out of these 37 patients; there were 11 (8%) with PSA <20; and 4(5%) with PSA <10 (PSA values:1.89,7.37, 7.6 and 8.73). There were 5 patients with PSA < 20 who had moderately differentiated cancer and of these 4 had PSA <10.
Conclusion: Bone scanning may be necessary in newly diagnosed cases of prostate cancer with PSA < 20ng/ml. Our study indicates that a larger proportion of patients in this category may have a positive bone scan than earlier studies have shown. It is important not to over-treat these patients with radical treatment, as would occur without the information provided by bone scans. Limiting the number of bone scans in a cost saving effort may therefore compromise patient care.

SUCCESSFUL OUTCOME AFTER LAPAROSCOPIC FUNDOPLICATION IN PATIENTS WITH DOCUMENTED GASTRO-OESOPHAGEAL REFLUX FOLLOWING LUNG TRANSPLANTATION

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Aims: To evaluate the prevalence of severe gastro-oesophageal reflux (GORD) following lung transplantation and outcome after laparoscopic fundoplication.
Methods: A retrospective analysis was performed on all patients who developed severe GORD requiring laparoscopic fundoplication following single or bilateral lung transplantation at a single institution from 2002-2009. GORD was confirmed by oesophageal manometry and 24 hour pH/bile monitoring. Pre and post-operative pulmonary function tests were analysed.
Results: 10 of 76 lung transplant patients (13.2%) underwent laparoscopic fundoplication. All patients were already on a H2 antagonist or proton-pump inhibitor. Of these 10 patients, pH studies demonstrated severe acid/bile reflux with delayed clearance. 1 patient could not tolerate oesophageal manometry but demonstrated endoscopic signs of severe reflux oesophagitis. The mean total reflux time over 24 hours was 12.4% (normal <4%). The mean total number of reflux episodes over 24 hours was 152. The average De Meester composite score was 48.2 (normal <14.72). 4 patients had upper oesophageal reflux, which was considered significant. The average time from transplantation to fundoplication was 26.2 months. All procedures were completed laparoscopically and the 30 day mortality was zero. After fundoplication surgery, 8 of 10 patients demonstrated improvement in pulmonary function (80%) and resolution of reflux symptoms was achieved in 90%.
Conclusions: GORD occurs commonly in patients following lung transplantation. Laparoscopic fundoplication can be performed safely with reduction in the risk of microaspiration, diffuse alveolar damage and allograft failure, resolution of GORD symptoms and improvement in respiratory function.

INTRA-OPERATIVE SELECTIVE RENAL ARTERY BALLOON OCCLUSION LAPAROSCOPIC RADICAL NEPHRECTOMY – TECHNIQUE AND OUTCOMES

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